

Mental Health Disparities

Mental health disparities have received increased attention in the literature in recent years. After considering 165 different health disparity conditions, the Federal Collaborative for Health Disparities Research chose mental health disparity as one of four topics warranting its immediate national research attention. In this essay, we describe the challenges and opportunities encountered in developing a research agenda to address mental health disparities in the United States. Varying definitions of mental health disparity, the heterogeneity of populations facing such disparity, and the power, complexity, and intertwined nature of contributing factors are among the many challenges. We convey an evolving interagency approach to mental health disparities research and guidance for further work in the field. (*Am J Public Health*. 2009;99:1962–1966. doi: 10.2105/AJPH.2009.167346)

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THE LAST 2 DECADES HAVE

brought increased attention to the issue of mental health disparities (Figure 1). For example, many rural Americans have less access to mental health services than do other Americans, suicide rates vary with respect to a variety of demographic variables, and persons with the lowest level of socioeconomic status are estimated to be about 2 to 3 times more likely to have a mental disorder than are those with the highest level of such status.¹ The Surgeon General's 2001 report, *Mental Health: Culture, Race and Ethnicity*,¹ noted that, with the increasing diversity of our population, it is in the best interests of the nation to make sure that all of our populations are as healthy as they can be. Both the Institute of Medicine and the National Institutes of Health (NIH) have prioritized disparities in mental health on their research agendas, and The President's New Freedom Commission on Mental Health included elimination of disparities as one of six goals for transforming the mental health system.

Representatives of more than twenty United States government agencies convened in 2006 to promote research whose results would help reduce health disparities and guide effective public health policies. Resources were limited, so this consortium, which came to be known as the Federal Collaborative for Health Disparities Research (FCHDR), had to make difficult prioritizing decisions. After considering 165 different health disparity conditions, FCHDR selected mental health disparity as

one of the four topics warranting its most immediate national research attention. The other 3 topics selected were: obesity, comorbidities, and the built environment.

FCHDR established a science group to address each of its four priority topics. The Mental Health Science Group included staff from the National Institute of Corrections, Centers for Disease Control and Prevention (CDC), Indian Health Service (IHS), NIH, Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Women's Health, and other components of the Department of Health and Human Services (HHS).

In this essay, we describe some of the challenges and opportunities encountered in developing a research agenda to address mental health disparities in the United States.

MULTIPLE CHALLENGES AND QUESTIONS

The Mental Health Science Group reviewed scientific literature, considered prior experience of individual member organizations and their research, and considered unmet needs of the population. Early in its deliberations, the group recognized that the sheer enormity of the topic assigned to it, i.e., mental health disparity, and the diversity of the group itself meant that there were multiple opinions on how to proceed. No one research project, approach, or paper would be sufficient to address, or even fully recognize, the vast universe of mental health disparity that existed. Yet, certain key questions emerged

whose answers, and the quest for them, would guide this new science group's next steps (see the box on the next page).

DEFINITION OF MENTAL HEALTH DISPARITY

Mental health disparity, like other forms of disparity, is defined in various ways by different agencies, depending on agency focus and expertise and on the purpose and context of the definition. For example, Mental Health Science Group representatives from NIH's National Institute of Mental Health (NIMH) consider mental health disparity as a significant disparity in the overall rate of mental illness incidence or prevalence, morbidity, mortality or survival rates in a health disparity population as compared with the health status of the general population.

SAMHSA, the nation's lead mental health service agency, currently defines health disparity as the power imbalances that impact practices influencing access, quality, and outcomes of behavioral health care, or a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rate in a specific group of people defined along racial and ethnic lines, as compared with the general population (working definition). The Office of Women's Health examines health disparities in the context of gender issues. The National Institute of Corrections focuses on health disparities facing populations in the correctional system, e.g., high rates

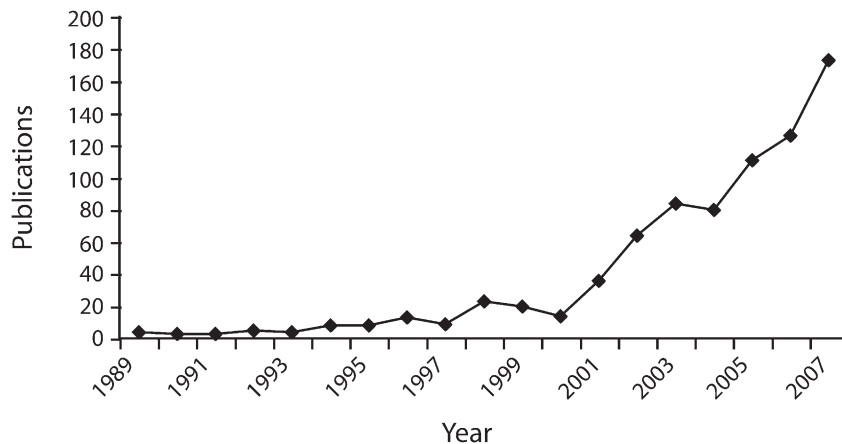


FIGURE 1—Number of publications on mental health disparities, by year: 1989–2007.

of mental disorders but poor access to quality mental health care.

All of the definitions discussed thus far essentially consider mental health disparities as disparities of health, health services, or health determinants. The CDC definition is probably the most unifying of these agency-specific definitions and considers mental health disparities as disparities present within the field of public health, health systems, and society. The CDC definition describes mental health disparities as often falling into one of these three categories: (1) disparities between the attention given mental health and that given other public health issues of

comparable magnitude, (2) disparities between the health of persons with mental illness as compared with that of those without, or (3) disparities between populations with respect to mental health and the quality, accessibility, and outcomes of mental health care. In addition, CDC scientists often discuss social determinants, such as employment, income, housing, and so on, which can influence mental health and access to care.

ACCESS TO MENTAL HEALTH SERVICES

The surgeon general in 1999 estimated that about one in four

Americans had a mental disorder and that two thirds of those with mental disorders did not receive treatment.² A recent survey conducted by Harris Interactive and the American Psychological Association determined that 25% of the US population lacks adequate access to mental health care.³ To address insurance coverage disparities that make mental health care less accessible than other forms of health care, the recently enacted Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act of 2008 requires equal coverage for mental and nonmental illness for

plans that include mental health coverage (excluding those offered by employers with 50 or fewer employees). The legislation does not require plans to include mental health coverage. The full impact of the legislation is unlikely to be discerned without high quality program evaluation that includes longitudinal surveillance and representation from all segments of American society.

SPECIAL POPULATIONS AND UNIQUE CHALLENGES

A variety of populations in the United States face unique mental health disparities. Such populations include women, men, American Indians and Alaska Natives (AIANs), African Americans, Hispanic Americans, Asian Americans, children, older adults, veterans, sexual minorities, rural residents, urban residents, the unemployed, refugees, the incarcerated, and other special populations. Each has various population-specific characteristics and distinctive mental health needs. People within these populations also have varying individual characteristics and needs that differ from those of other members of the same group. Naturally, some people will be part of multiple different populations. The daily overlapping and sometimes unpredictable patterns of people and populations interacting in the world make mental health disparities research especially challenging.

Sometimes, researchers will lump together “race-specific” measurements to describe a group of people, despite major intragroup differences, because some ancestors came from a particular region of the world or they have some superficial but

Questions Identified by the Mental Health Science Group (MHSG) of the Federal Health Disparities Collaborative, United States, 2006–2008

- What are the numerics of Mental Health Disparities (MHDs)?
- How are MHDs measured?
- What are the validity/reliabilities of instruments in relation to MHD populations?
- How can we improve the validity/reliability of the diagnostic process across MHD populations?
- What is the optimal mental health research infrastructure capacity, and where should it be initiated, expanded, or terminated?
- What is outreach and dissemination research?
- What research should the MHSG endorse?
- How can the MHD research effort be better organized?
- Where should the MHSG research effort begin?
- How will we know when the FCHDR MHSG effort has made a difference?

particular physical differences from the majority population.⁴ Such a shared “ethnic gloss”^{5,6} can be deceptive, as, for example, in the case of American Indians/Alaska Natives (AIANs). Although comprising only 1%–2% of the US population, AIANs have been estimated to provide 50% of the nation’s diversity.⁷ With over 560 federally recognized tribes and over 400 indigenous languages¹ (some of which are no more closely related than English to Chinese⁸), there are few general statements that accurately describe the native culture of North America. Tribal cultures vary enormously.⁹ Perhaps, among the only things that all AIANs have in common are that their ancestors discovered America and that they share recent family histories of invasion, oppression, and trauma.

Any discussion of disparities in mental disorders or other aspects of mental function requires recognition of the limits of what is measured, what is known, and how it is referred to, especially when discussing survey results of Americans of varied cultural and linguistic groups. The diagnostic systems and terms frequently used have historically been based on distinctive and Eurocentric views of the world and of human behavior.^{10–13} These views are not necessarily shared by members of other cultures.^{14–20} Cultural limitations of standardized diagnostic systems are recognized by the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*, and the development of the diagnostic system presented in the *DSM-IV-TR* included extensive efforts to minimize such limitations.²¹ Although many investigators and clinicians are aware of the cultural limitations of standardized diagnostic systems, associated

caveats are often forgotten when assessing findings based on such systems.

When research instruments are used in large epidemiologic surveys to arrive at diagnoses in various populations,^{22–29} there are also associated caveats to remember. The field of psychometrics relies on the premise of measuring test results from a population under examination against a reference or “normal” population,^{30–32} yet what is considered “normal” with respect to mental health in one culture may not necessarily be considered “normal” in another. Likewise, a psychometric test that is useful in identifying normality in one culture may not be useful in another. Dissemination of research findings based on culturally nonvalid psychometric assessments could potentially cause clinical harm, experienced as “pathologization, caricature, and even humiliation for many native people.”^{33(p218)}

In researching mental health disparities in AIAN and other nonmajority populations, it is important that the measures are culturally valid and scientifically comparable,³⁴ and that they are used carefully. Possible adverse effects of the conduct of the research and of potential findings should be considered.

THE CORRECTIONAL SYSTEM AS A SITE OF MENTAL HEALTH DISPARITY

Another very different yet also heterogeneous and disparate population is that of the correctional system in the United States. The intertwined psychological and social challenges that impact the mental health of this population warrant further study and may themselves be influenced by the

history of the correctional system over the past century.

The advent of efficacious drug treatment, and humanitarian pressures to treat patients with dignity and freedom led to the closing of psychiatric institutions in favor of delivering mental health care in a community setting (deinstitutionalization). Deinstitutionalization of mental health care was only half accomplished; although the closing of state mental hospitals occurred, the more complicated task of creating effective community mental health systems never fully materialized.³⁵

Consequently, emergency rooms and local jails became the destination of individuals manifesting disturbing behavioral symptoms in public settings. Because emergency rooms were only obligated to provide short-term acute care, jails and prisons became primary mental health providers. Although correctional systems were never designed to function as mental health hospitals, the courts have determined that there is a Constitutional responsibility for the government to provide mental health care for incarcerated persons in need of such care.^{36–38}

Delivery of mental health care in a correctional setting presents many challenges. First, the overall health status of offenders is often poor when they enter the criminal justice system. Offenders often have histories of substance abuse, violence, and risky life styles. Security and safety concerns inside prisons make health care delivery more difficult and costly.

Over 50% of offenders have at least one mental disorder, with females experiencing higher rates of disorders than males.³⁹ More than half of all state inmates report mental health difficulties, and close to 17% are diagnosed with a serious mental illness.⁴⁰ Nationwide,

over a million of those imprisoned have a serious mental illness.⁴¹ Rates of mental illness among those incarcerated, on parole, or on probation, are greater than the rates of mental illness seen in the general population. Over 5 times as many people with mental illnesses are in jails and prisons than are in all of the few remaining state psychiatric hospitals combined.⁴⁰

Correctional health is not isolated from community health. Health status “inside the walls” affects health status outside and vice versa, and 97% of all incarcerated offenders will eventually return to their communities. Evidence-based interventions must be implemented on both sides of the wall to be effective on either side.⁴²

The population within the correctional system is an identifiable group with documented health data, representing a distinct opportunity for mental health disparity reduction. Although mental health problems are commonly recognized in the correctional system, more research is needed to identify ways to increase access to mental health care for persons within that system who have mental health needs. More also needs to be learned about how to maximize the effectiveness of correctional mental health services and potential prevention strategies. Racial disparities in the prevalence of incarceration itself also warrant further attention.⁴³

A VISION OF SUCCESS

Mental health disparities are complex, challenging problems that involve multiple determinants at the individual, community, program, system, and policy levels. They present a special challenge to government because they defy precise definition, cut across policy

Objectives Selected by the Mental Health Science Group of the Federal Health Disparities Collaborative, 2006–2008

- Understand the neuronal and behavioral basis of mental disorders and how they deviate from normal processes.
- Develop reliable, valid diagnostic tests and biomarkers for mental disorders.
- Define the genetic and environmental risks architecture of mental disorders.
- Develop interventions to prevent occurrence or reduce relapse of mental disorders.
- Develop more effective treatments that have minimal side effects, reduce symptoms and improve daily living.
- Conduct clinical trials that will provide practitioners with treatment options to deliver more effective personalized care across diverse populations.
- Create improved pathways for dissemination of science to mental health care and service providers, policy-makers, bill-payers, and other consumers.

Note. An underlying premise of these objectives is the need for a variety of scientific approaches, ranging, for example, from laboratory research to community-based participatory research.

and services areas, and often resist solutions offered by the single-agency or “silo” approach.⁴⁴

The FCHDR’s Mental Health Science Group brings together representatives from different federal agencies to collectively address mental health disparity research despite variations in definitions, perspectives, research models, and approaches to mental health disparities. The resulting scientific discourse signals exciting activity. Although this group is in its formative stages, it has crafted a vision for further research to eliminate mental health disparities (see the box on this page) and a plan that includes the following indicators of success:

- Development of a framework for understanding mental health disparities;
- Identification of the relevant categories of mental health disparities research that cut across multiple service sectors and research areas;
- Articulation of the comprehensive and wide-ranging methodologies in this research, inclusive of basic science and biomedical approaches;
- Utilization of technology to support collaborative research and

timely dissemination and diffusion of the research findings in a coherent, coordinated approach;

- Development of a system of measurable targets and proxy indicators to track the status, progress, and impact of the Mental Health Science Group and of mental health disparities research; and
- Collaborative funding of research projects that are designed to eliminate mental health disparities.

It is our hope that many more researchers will address mental health disparities and that their research will yield knowledge that will help eliminate major mental health disparities in our nation. The FCHDR’s Mental Health Science Group seeks to facilitate better monitoring of research needs, promote collaboration and translation, and develop better evaluation strategies to ensure that research efforts yield a meaningful reduction in mental health disparities throughout the nation. ■

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Contributors

M. A. Safran led the article’s overall development from the early outline to the finished product, including development of consensus and the melding of differing concepts and topics. M. A. Safran, R. A. Mays Jr, L. N. Huang, R. McCuan, P. K. Pham, S. K. Fisher, K. Y. McDuffie, and A. Trachtenberg each took the lead in drafting individual portions of the article related to their unique areas of expertise and collaborated in the article’s overall development and editing.

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